TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Surgicare Plano

Respondent Name
Fidelity & Guaranty Insurance

MFDR Tracking Number
M4-15-1889-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowed amount of the procedure is $35,265.65."

Amount in Dispute: $4,730.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgment of medical fee dispute received however; no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 3, 2014	63685, 63650, 65650-59, 95972, L8687, L8680, L8681, Implant Interest	$4,730.63	$1,052.08

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the reimbursement guidelines for services in an Ambulatory Surgical Center Fee Guideline.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 983 – Charge for this procedure exceeds Medicare ASC schedule allowance
   - 4123 – Allowance is based on Texas ASC Device intensive procedure calculation and guidelines
   - 193 – Original payment decision is being maintained
   - 86 – Service performed was distinct or independent from other services performed on the same day
   - 247 – A payment or denial has already been recommended for this service
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment

- 170 – Reimbursement is based on the outpatient/inpatient fee schedule
- 943 – Documentation does not support billed charge. No recommendation of payment can be made
- W3 – Additional payment made on appeal/reconsideration

Issues

1. What is the applicable rule pertaining to services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute relates to services performed in an Ambulatory Surgical Center with requested implants. 28 Texas Administrative Code §134.402 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register.
>
> Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor…
>
> (2) Reimbursement for device intensive procedures shall be:
>
> (A) the sum of:
>
> (i) the ASC device portion; and
>
> (ii) the ASC service portion multiplied by 235 percent; or
>
> (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of:
>
> (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
>
> (ii) the ASC service portion multiplied by 235 percent."

Review of ADDENDUM AA at cms.hhs.gov., for 2014 finds;

1. 63685 - July 2014 Payment Indicator J8, July 2014 Payment Rate $16,172.35
2. 63650 – July 2014 Payment Indicator J8, July 2014 Payment Rate $3,691.78
3. 63650 -59 – July 2014 Payment Indicator J8, July 2014 Payment Rate $3,691.78

Review of ADDENDUM DD1 Final ASC Payment Indicator for CY 2014 at cms.hhs.gov., finds;

Indicator	Payment Indicator Definition
J8	Device-intensive procedure; paid at adjusted rate

2. The maximum allowable reimbursement for the services in dispute is as follows;

Submitted Code	APC off set %	CMS Addendum AA ASC Reimburse ment	Core based statistical Area	CBSA Wage Index	Device Portion	Calculation of Geographically adjusted Medicare ASC	Service Portion Subtract device portion from geographically adjusted ASC reimbursement Multiply by 235%	Add the sums of the service portion and implantables
63685	86.25%	$16,172.35	19124	1.0068	OPPS $17,232.90 x 86.25% = $14,863.38	$16,172.35 ÷ 2 = $8086.18 Multiply this total by CBSA wage index ($8086.18 x 1.0068 = $8,141.17) Add both together (8086.18 + 8141.17) = $16,227.35	$16,227.35 – 14,863.38 = $1,363.97 x 235% = $3,205.33	$3,205.33 Supported Invoice Amount $21,900.00 Add-on per item $1,000.00 Total $26,105.33
63650	54.86%	$3,691.78	19124	1.0068	$4,626.50 x 54.86 = $2,538.10	$3,691.78 ÷ 2 = $1,845.89 x 1. 0068 = 1858.44 1845.89 + 1858.44 = $3,704.43	3704.43 – 2538.10 = $1166.33 x 235% = $2,740.88	2,740.88
63650-59	54.86%	$3,691.78	19124	1.0068	$4,626.50 x 54.86 = $2,538.10	$3,691.78 ÷ 2 = $1,845.89 x 1. 0068 = 1858.44 1845.89 + 1858.44 = $3,704.43	3704.43 – 2538.10 = $1166.33 x 235% = $2,740.88	2,740.88
							TOTAL	$31,587.09

The total allowable for the services in dispute is $31,587.09. The carrier previously paid $30,535.01. An additional payment of $1,052.08 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,052.08.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,052.08 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.